

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First KRISTA		Middle D.		Last ALLEN		2a. DATE OF DEATH Month JUNE Day 9 Year 1969			
3. SEX FEMALE			4. RACE WHITE		5. DATE OF BIRTH 7-14-1968			6. AGE (In years last birthday) YRS. 10		2b. HOUR 4:20 PM		
7a. BIRTHPLACE (State or foreign country) W.VA.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during usual working life, even if retired.) NONE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W.VA.			13b. COUNTY MINERAL			13c. CITY OR TOWN KEYSER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 4		
14. FATHER'S NAME First PAUL Middle Last ALLEN			15. MOTHER'S MAIDEN NAME First JUDITH Middle Last TASKER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PURULENT MENINGITIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 6/6 , 19 69 , to 6/9 , 19 69 , that (I) (we) lost saw the deceased alive on 6/9 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert J. Dawson MD						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/11/69				
22d. PHYSICIAN'S NAME (Type) ROBERT J. DAWSON						22e. ADDRESS 500 GREENE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12 June 1969		23c. NAME OF CEMETERY OR CREMATORY Tasker		23d. LOCATION (City or Town) (County) (State) Cross Mineral W.Va.					
24. FUNERAL DIRECTOR Allen M. Rotruck						ADDRESS Keyser, W. Va.		25a. REC'D BY REGISTRAR JUN 16 1969		25b. REGISTRAR'S SIGNATURE W. L. Jones Judge		

07307

07307



RECEIVED

WHITE

ALLER

JUNE

2, 1966

to

5-11-1966

ALLER

U. S. A.

W. W.

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

W. W.

CONFIDENTIAL

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No

CONFIDENTIAL

ROBERT J. DAWSON

500 GREEN ST., CLEVELAND, OH.

Serial 12 June 1966

Tolson

Cross

Richard W. V.

Richard W. V.

CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

07708

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07699

1. DECEASED-NAME (Type or print)			First MINNIE	Middle NMI	Last ARNOLD	2a. DATE OF DEATH Month 06 Day 17 Year 69			2b. HOUR P 11:35M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10-23-89		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HOURS HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife,		12b. KIND OF BUSINESS OR INDUSTRY own home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Bowling Green 41 CRESAP DRIVE			
14. FATHER'S NAME JAMES			First EDWARDS		Last (JONES) ELIZABETH		15. MOTHER'S MAIDEN NAME EDWARDS		First EDWARDS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no NO (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-10-4674		17. INFORMANT SACRED HEART, SETON DR, CUMB., MD. 21502						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6-12-69 , 19 69 , to 6-17-69 , 19 69 , that (I) (we) lost saw the deceased alive on 6-17-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE L. BRNGS						DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-18-69	
22d. PHYSICIAN'S NAME (Type) L. BRNGS, M.D.						22e. ADDRESS 57 GREENE ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/20/69		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d. LOCATION (City or Town) (County) (State) Eckhart, Allegany Maryland					
24. FUNERAL DIRECTOR H. Wayne George						ADDRESS MD. 21502		25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles J. Smith	

0770

0768



MINUTE 17 05 11:32

WHITE 10-22-10

ALL GARY COUNTY, X

JACKED HEAD H. STIAL

ALL GARY COUNTY, X

JAMES (JAMES) ELLIOTT

JACKED HEAD, SETON DR., CHIB., NO. 21502

27 GREENE ST., CHIB., NO. 21502

GEORGE FINE V. L. HOME, 202 GREENE ST., CHIB., NO. 21502

4389

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07709

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07700

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
HARRY			R.		ASH	06 Month 30 Day 69 Year			10:30A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		11-5-96		73 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		UNITED STATES				ALLEGANY COUNTY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			MEMORIAL HOSPITAL			RETIRED-KELLY ST. CO.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MD.			ALLEGANY CO.		FLINTSTONE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JACKSON					ASH	JENNIE					DIEHL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 211-05-9954			17. INFORMANT Address MEMORIAL HOSPITAL CUMB. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
						City of Allegany Md					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/69</u> , 19 <u>69</u> , to <u>7/3/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>7/2/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>DR. R. J. WILLIAMS</u>			22c. PHYSICIAN'S NAME (Type)			22e. ADDRESS		DEGREE <input checked="" type="checkbox"/> ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/3/69</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7/3/69		23c. NAME OF CEMETERY OR CREMATORY Everett Pa Cemetery			23d. LOCATION (City or Town) (County) (State) Everett Bedford Penna			
24. FUNERAL DIRECTOR ADDRESS 21502			25a. REC'D BY REGISTRAR JUL 7 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
Silcox-Merritt Funeral Service, Cumberland, Md											

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07710

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07701

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Marshall Warren Barthalow						June 28, 1969			1:30a			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	12/ 7/1907	61 YRS.					June 28, 1969			1:30a M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Penna.			U S A						Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Frostburg			Miner's Hospital--DOA			Dept 43			Kelly Springfield					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Md.			Allegany			Flintstone			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route 1		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Clay			Barthalow			Mazie			Ruby					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			216-22-5685			Ruth Fisher Barthalow			Route 1, Flintstone Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Maceration of Brain												2 Hours		
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Skull Fracture												"		
DUE TO, OR AS A CONSEQUENCE OF (c) (Auto Accident)												"		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
About 11:30 PM				6-27-69				Passenger in Auto Accident						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
Rt. # 40				1.3 miles east from top Martin Mt. Allegany, Maryland										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED						
BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				June 28, 1969						
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)				Cumberland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY						
Burial				7/1/69				Chaneysville Meth. Cem.						
24. FUNERAL DIRECTOR				23d. LOCATION (City or Town) (County) (State)				25a. REC'D BY REGISTRAR						
Charles E. Hafer				Chaneysville, Bedford, Penna.				JUL 2 1969						
Charles E. Hafer, 230 Balto Ave. Cumberland Md				25b. REGISTRAR'S SIGNATURE				Charles Judge						

0100

0100

June 28, 1969

June 28, 1969

Medical Examination

Medical Examination

Medical Examination

2 hours

Examination of brain

Spinal fluid

(Auto accident)

X

June 28, 1969 6-27-69 Passenger in auto accident

1.3 miles east from top of hill in N. direction, leveling

June 28, 1969

BRUNNEN KILN, N.D.

June 28, 1969

June 28, 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07711				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07702					
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR		
MARGARET						BEAL	JUNE Month 1, Day 1969 Year				7 40 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE		WHITE		JANUARY 10, 1894			75 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH							
MARYLAND		U.S.A.		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
FROSTBURG		MINERS HOSPITAL		HOUSE WIFE									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MARYLAND		ALLEGANY		FROSTBURG		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		KEMP DRIVE					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
First Middle Last		First Middle Last											
DAVID		JONES		ALICE		LEWIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address							
				JACK BEAL,		ECKHART, MD. 21528							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Decompensation CVD</u>												2 weeks	
4124 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												years.	
(b) <u>arteriosclerosis</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED									
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year		(Enter nature of injury in Part 1 or Part 2, Item 18.)									
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from May 19 69, to June 1, 19 69, that (I) (we) last saw the deceased alive on June 1, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED											
John B. Davis		6/2/69											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
JOHN B. DAVIS, M. D.		2 BROADWAY, FROSTBURG, MD. 21532											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
BURIAL		JUNE 3 '69		FEB. MEMORIAL PARK		FROSTBURG, MD.							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JOSEPH R. DURST, FROSTBURG, MD. 21532						JUN 4 1969		Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
May		Anna	Beall		June Month 11 Day 69 Year		127P ^M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female		White		7-20-82		86 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		USA				Allegany Md.			
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Cumberland Nursing Center		Footers Cleaners Foreman		Dry Cleaners			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		604 Maryland Ave.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Martin				Rizer	Amelia				Willison
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				217-10-4463		Thomas Beall Husband 604 Maryland Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation recurrent</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis Cardiac Vasc. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Exhaustion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (his hospital) attended the deceased from <u>23 Apr 1969</u> , to <u>59 Apr 1969</u> , that (I) (we) last saw the deceased alive on <u>23 Apr 1969</u> , and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
David T. Rees M.D.		12 June 69			DAVID T. Rees M.D.				
					22e. ADDRESS				
					Box Montgomery Ave Cumberland Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/14/69		Greenmount Cemetery		Cumberland Allegany Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William G. Kight		Cumberland, Md.		JUN 19 1969		[Signature]			

07703

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OFFICE OF THE

General Manager - General Manager

William E. Knight - General Manager

5719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07718		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07704			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
. CLARENCE FRANCIS BEEM						Month 6 Day 17 Year 69		10:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		WHITE		4-27-18		51 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
ILLINOIS		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		CLAIM DEPT.		B & O RR CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND		X		330 RESERVOIR AVE.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
FRANCIS BEEM		(MARY) Margaret Sexton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
X Yes War II		344-16-707		HOSPITAL CHART		900 SETON DRIVE CUMBERLAND, MD. 21502			
PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5719		Massive Gastrointestinal Bleeding				12 hr			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		1 wk			
		Hepatic Failure		(c)		1 yr			
		Hepatic Cirrhosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6-13, 1969, to 6-17, 1969, that (I) (we) last saw the deceased alive on 6-17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
L. Michael Glick		6-17-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
L. MICHAEL GLICK, M.D.		912 SETON DRIVE CUMB., MD. 21502							
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 20, 1969		St. Mary's Cemetery		Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SCARPELLI FUNERAL HOME		108 VA. AVE., CUMBERLAND, MD. 21502		JUN 24 1969		Charles Judge			

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CLARENCE . FRANCIS BEEN

WHITE 12-27-12 ALLEGAY

CLARENCE BEEN ALLEGAY 330 RESERVOIR AVE.

FRANCIS BEEN SACRED HEART HOSPITAL

L. MICHAEL CLICK, N.D. 312 SETON DRIVE

SCARLETT FINNELL H.M. 10 AVE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07714		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07705	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
MICHAEL				BEEMANBEERMAN	6 Month 13 Day 69 Year		8:20PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		Feb. 16, 1904		65 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Penna	U.S.A.				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		ALLEGANY		CUMBERLAND		13e. STREET AND NUMBER 815 BRADDOCK RD.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last		
Isreal				Beerman	Rachel Levinson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. IN		Address	
				SACRED HEART HOSP. EMERGENCY RM. RECORDS		900 SETON DR. CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION							
4109 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
DIABETES MELLITUS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 19 63, to 13 JUNE 19 69, that (I) (we) last saw the deceased alive on 9 JUNE 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		L. M. GLICK, MD.		22c. DATE SIGNED		6-13-69	
22d. PHYSICIAN'S NAME (Type)		L. M. GLICK, MD.		22e. ADDRESS		912 SETON DR., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6/15/69		East View Cem.		Cumberland Allegany MD	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
STEIN'S FUNERAL HOME		117 FREDERICK CUMBERLAND, MD.		JUN 17 1969		Charles Judge	

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ENERGENCY IN. REEDS

CUNBERLAND, NO.

L. M. GLICK, MR.

012 SETON DR., CUNBERLAND, NO.

117 FREDERICK
CUNBERLAND, NO.

ST. JES. F. VEAL HAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07715MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07706

1. DECEASED-NAME (Type or print) Margaret E. Bell			2a. DATE OF DEATH Month 6 Day 20 Year 1969			2b. HOUR 3-30 P				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10/26/1900		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Wva.		7b. CITIZEN OF WHAT COUNTRY? USA.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER High Street		
14. FATHER'S NAME First Joseph Middle Elkins			15. MOTHER'S MAIDEN NAME First Mary Middle Gay			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.	
17. INFORMANT Glenn Bell			Address Lonaconing, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 436.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 10 days years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June 20, 1969 , to June 20, 1969 , that (I) (we) last saw the deceased alive on June 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (and) (did not) view the body after death.										
22b. SIGNATURE L.R. Miles, Jr.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6.21.69				
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR. M.D.		22e. ADDRESS LONACONING MD 21537								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/23/1969		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.				
24. FUNERAL DIRECTOR George Eichhorn				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 2 and 3, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07716

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07707

1. DECEASED-NAME (Type or print)			First Pora	Middle Mae	Last Bishop	2a. DATE OF DEATH Month Day Year 6/16/1969			2b. HOUR M 	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4/19/1885			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.			13b. CITY OR TOWN Allegany Lonaconing			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last James W Bishop			15. MOTHER'S MAIDEN NAME First Middle Last Matilda Sperry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 220-34-1920			17. INFORMANT Address Alban Bishop Lonaconing, Md. (Brother)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days years years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Intestinal obstruction (Gastric Ulcers)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from June 15, 1969 , to 6-16, 1969 , that (I) (we) last saw the deceased alive on June 15, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE L. R. Miles						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6.16.69		
22d. PHYSICIAN'S NAME (Type) L. R. MILES						22e. ADDRESS Lonaconing Md 21539				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/18/1969		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City or Town) (County) (State) Westernport, Md.			
24. FUNERAL DIRECTOR ADDRESS George Eichhorn Lonaconing, Md.						25a. REC'D BY REGISTRAR DATE JUN 19 1969		25b. REGISTRAR'S SIGNATURE John A. Judge		

07210

Port of Origin: [illegible]

Species: [illegible]

Sex: [illegible]

Age: [illegible]

Weight: [illegible]

Height: [illegible]

Color: [illegible]

Measurements: [illegible]

Observations: [illegible]

Remarks: [illegible]

Collector: [illegible]

Date: [illegible]

Location: [illegible]

Time: [illegible]

Weather: [illegible]

Notes: [illegible]

Signature: [illegible]

Stamp: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

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07717

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

077DB

1. DECEASED NAME (Type or print) First Middle Last <i>Vera Virginia Borgman</i>			2a. DATE OF DEATH Month Day Year <i>June 10 1969</i>		2b. HOUR Min <i>4:30</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>June 2, 1890</i>		6. AGE (In years last birthday) <i>79</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Allegheny</i>		
10. CITY OR TOWN OF DEATH <i>Sonoma Md</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kyle Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Allegheny</i>	13c. CITY OR TOWN <i>Cumberland</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>Bedford Road</i>	
14. FATHER'S NAME First Middle Last <i>John Jose</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>Nellie Rowe</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16b. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Mrs. Irene McElfish Cumb. Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Ischemia</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i> <i>4 years</i> <i>10 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic Semipathy</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 9, 1969</i> , to <i>June 9, 1969</i> , that (I) (we) last saw the deceased alive on <i>June 9, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>L.R. Miles, Jr. M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <i>L.R. MILES, JR., M.D.</i>		22e. ADDRESS <i>Sonoma, Md 21539</i>		22c. DATE SIGNED <i>6-10-69</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6/13/69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Marys Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Cumberland, Allegheny Md</i>		
24. FUNERAL DIRECTOR <i>Louis Stein Inc Cumb. Md</i>		ADDRESS <i>Cumb. Md</i>	25a. REC'D BY REGISTRAR DATE <i>JUN 12 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles [Signature]</i>

1000

FOR STATE HEALTH DEPT.

07718

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07709

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Douglas James Carey						Month Day Year			8:30 P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	June 15, 1951	18 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			8:30 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
Maryland		U S A		NEVER MARRIED		Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Sacred Heart Hospital			Student					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Allegany			Frostburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
James Carey			Agnes Wilhelm			Star Route					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			215-58-6331			James Carey, Star Route, Frostburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:									25 Hours		
IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE, CEREBRAL EDEMA											
DUE TO, OR AS A CONSEQUENCE OF											
(b) BASILAR SKULL FRACTURE											
DUE TO, OR AS A CONSEQUENCE OF											
(c) MACERATION OF BRAIN											
PART 2. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION				19b. CONITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
about 7:30 PM			6-24-69			Passenger--fell from moving vehicle					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		
M R #78			Edge of Frostburg, Allegany, Maryland								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		
Burial			June 28, 1969			Blocker Cemetery			Garrett (State)		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John J. Hafer, Jr.			270 Ave. Cumberland			JUN 27 1969			Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible handwritten notes]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07719

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07719

1. DECEASED-NAME (Type or print)		First VERNON	Middle ALBERTUS	Lost CRABLE	2a. DATE OF DEATH Month 6 Day 23 Year 69		2b. HOUR 9:35AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-24-10		6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Japanese Silk			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY Allegany		13c. CITY OR TOWN CORRIGANVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Hilltop Drive	
14. FATHER'S NAME First HARRY Middle S. Lost CRABLE		15. MOTHER'S MAIDEN NAME First ANNA Middle PRESTON Lost							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 217-10-7570		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterial hypertension									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 4 yr 6 yr
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-27, 1969 to 6-22, 1969 , that (I) (we) last saw the deceased alive on 6-22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles P. Gross		DEGREE DR. V. DROSS		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-24-69	
22d. PHYSICIAN'S NAME (Type) DR. V. DROSS		22e. ADDRESS CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/26/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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07110

VERSION / EMBROID / CABLE

MALE WHITE 11-24-10

MALELAND U.S.A. ALLEGANY

CUMBERLAND MEMORIAL HOSPITAL

MALELAND ALLEGANY CUMBERLAND

MALELAND ALLEGANY CUMBERLAND

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3489
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

07720		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07711					
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
LOUIS				NMI	D'ALESSANDRO	06 25 69			10:37A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		03-28-03		66 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		MD.			
ITALY		USA				ALLEGANY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSP.			RETIRED			NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			ALLEGANY		CUMBERLAND				726 OLDTOWN RD.,		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
DOMINIC					D'ALESSANDRO	LAURA					BLACIOLI
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
NO			214-05-8846		HOSPITAL REC., 900 SETON DR., CUMB., MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA ACUTE & CHRONIC, DUE TO</u> <u>3489</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASPIRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PARALYSIS OF SOFT PALATE & vocal cords</u> DUE TO, OR AS A CONSEQUENCE OF <u>Gen muscular weakness due</u> (c) <u>Neuromuscular disorders, etiology unknown ?</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Heart disease - atherosclerosis & unknown muscular disorder duration 2y.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/17/69</u> <u>6 mos</u> <u>?</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>60</u> , to <u>6/25</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>6/25</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>S. G. WESSMAN</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/26/69</u>				
22d. PHYSICIAN'S NAME (Type) S. G. WESSMAN M.D.					22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		June 27, 1969		St. Peter & Paul Cem.			Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR <u>James F. Scarcelli</u>					25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD.											

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ITALY

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CHERLAND

SACRED HEART HOSP.

RETIRED

HOME

ITALY

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CHERLAND

200 CLOTHES

OPINION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07721										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07712									
1. DECEASED-NAME (Type or print) First MABEL Middle A. Last DEATELHAUSER										2a. DATE OF DEATH Month 6 Day 20 Year 69										2b. HOUR 11:15 AM									
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH 11-12-9-11-12-91					6. AGE (In years last birthday) 77 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) CUMBERLAND					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH ALLEGANY Md.														
10. CITY OR TOWN OF DEATH CUMBERLAND					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HWF					12b. KIND OF BUSINESS OR INDUSTRY HOME														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND					13b. COUNTY ALLEGANY					13c. CITY OR TOWN CUMBERLAND					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 21502 14 MASS. AVE., CUMB., MD.									
14. FATHER'S NAME First HENRY Middle WRIGHT Last					15. MOTHER'S MAIDEN NAME First INDIANA (SHOOK) Middle SHOOK Last																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO					16b. SOCIAL SECURITY NO. 214-05-9376					17. INFORMANT SACRED HEART HOSPITAL Pts CHART 900 SETON DRIVE CUMB., MD. 21502																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>suppurative pneumonia</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary-arterio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 6 months																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 2-31-1969, to 6-20-1969, that (I) (we) last saw the deceased alive on 6-20-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE L. Brings										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 6-21-69														
22d. PHYSICIAN'S NAME (Type) L. BRINGS, M.D.										22e. ADDRESS 57 GREENE ST., CUMB., MD. 21502																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE June 23, 1969					23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery					23d. LOCATION (City or Town) Cumberland, Allegany, Md. (County) (State)														
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME 108 VA. AVE. CUMB., MD. 21502										ADDRESS					25a. REC'D BY REGISTRAR JUN 24 1969					25b. REGISTRAR'S SIGNATURE Charles Judge									

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SCARBELLI, R. W. 1961. HORN LARKS. ILLINOIS

1829

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07722

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07714

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR M		
Priscilla			Jane		Evans	6/21/1969					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		Nov, 8th. 1921			47 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		Md.		
MD.		USA.					Allegheny				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Lonaconing						Celanese Employee					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MD			Allegheny Lonaconing					State Street			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Jacob				Click		Priscilla				Powell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No						Robert W. Evans, Cumberland, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma Uterus</u> 1829 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>69</u> , to <u>June 21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>L.R. Miles, Jr. MD</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-22-69			
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.						22e. ADDRESS LONA CONING, MD, 21539					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		6/24/1969		Memorial Park				Frostburg, Md.			
24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md.						25a. REC'D BY REGISTRAR JUN 26 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2159

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07723 Item 23 Film 413 6/20/69 kk									
CERTIFICATE OF DEATH									
07715									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
James Stanley Foard						June 13 1969		4: P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		July 24, 1896		72 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Allegany Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Memorial Hospital		Retired Carman		Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Allegany		Cumberland				1011 Virginia Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John R. Foard			Hannah E. Burkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes War I					Mrs. Berdie Foard, Cumberland, Md. Wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY: Acute Coronary Occlusion									
IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease									
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from June 13, 1969, to June 13, 1969, that (I) (we) last saw the deceased alive on June 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
G. Overton Himmelwright, M.D.		7-15-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
G. Overton Himmelwright, M.D.		133 Va. Ave, Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 16, 1969		Porter Cemetery		Cumberland (County) Md.			
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. REC'D BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.				JUN 17 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1										07724-										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07716																													
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
Nellie Mae Fraley																				Month Day Year										6 20 69 8:30 a. M.																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										11/29/1902										66 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Md										U.S.A.																				Allegany										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Cumberland										Memorial Hospital										House Work										Own Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Md										Allegany										Lonaconing										X										Beachwood Street																			
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																													
Theodore Knepp																				Martha Mathes																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										(If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																			
no																														William Fraley										Lonaconing, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
410.9										IMMEDIATE CAUSE (a) Myocardial infarction										6 weeks																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease.										years																																							
										DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 6/17, 1969, to 6/20, 1969, that (I) (we) last saw the deceased alive on 6/20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE P. B. HALMOS MD										22c. DATE SIGNED 6/24/69																																																	
22d. PHYSICIAN'S NAME (Type) PETER B. HALMOS										22e. ADDRESS 302 SCHLEY ST. CUMBERLAND																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										6/23/69										Oak Hill Cemetery										Lonaconing A. Md																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
George Eichhorn										Lonaconing, Md.										DATE JUN 26 1969										Charles Judge																													

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07725

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07717

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
CORA		M.		FREELAND	JUNE		Month	10, 1969 8:55PM
3. SEX	FEMALE		4. RACE	WHITE		5. DATE OF BIRTH	3-25-90	
7a. BIRTHPLACE (State or foreign country)	MARYLAND		7b. CITIZEN OF WHAT COUNTRY?	U. S. A.		8. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		HOUSEWIFE		OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
W. VA.		MINERAL		WILEY FORD		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		None
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
PETER				TWIGG	SARAH			ROBERTSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT				
no				MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) 197.8								3 mo.
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				Cumberland, Allegany, Md.				
22a. I certify that (I) (this hospital) attended the deceased from 4/13/69, 19, to 4/10/69, 19, that (I) (we) last saw the deceased alive on 4/10/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
R.J.WMS.		4/11/69						
22e. ADDRESS		22f. ADDRESS						
122 S. CENTRE ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		June 13, 1969		Hillcrest Burial Park		Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.				JUN 16 1969		Charles Judge		

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HOSPITAL

CHURCHMAN

None

WILEY FORD

WILEY FORD

W. V.

COLLEGE

W. V.

WILEY

WILEY

HOSPITAL, CHURCHMAN, W.

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122 S. CENTRAL ST., CHURCHMAN, W.

W. V.

June 1, 1902, Hinnerup Hospital, W. V.

June 1, 1902, Hinnerup Hospital, W. V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

07726		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07718	
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month <u>06</u> Day <u>18</u> Year <u>69</u>		2b. HOUR <u>5:45</u> MIN. <u>M</u>
ADAM		E.		FROST			
3. SEX MALE	4. RACE WHITE		5. DATE OF BIRTH 02-26-82		6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) KOPPERS COMPANY		12b. KIND OF BUSINESS OR INDUSTRY TOOL MAKER		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND	13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6 E. ROBERT STREET	
14. FATHER'S NAME First Middle Lost AUGUST FROST		15. MOTHER'S MAIDEN NAME First Middle Lost AUGUSTA FROST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-05-9317		17. INFORMANT Address SACRED HEART, SETON DR., CUMB., MD. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4124</u> LEFT VENTRICULAR FAILURE DUE TO, OR AS A CONSEQUENCE OF <u>ACVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 8 YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARRERIAL EMBOLISM INTO RIGHT LEG (TERMINAL)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-9</u> , 19 <u>66</u> , to <u>6-18</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>6-17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Rw Ballin</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-19-69</u>	
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.				22e. ADDRESS 62 GREENE STREET, CUMB., MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 20, 1969		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME, VIRGINIA AVE., CUMB.				25a. REC'D BY REGISTRAR JUN 24 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05328

07718

ADAM E. FROST 00-1 24:2

WHITE 02-28-12 17

MARYLAND U.S.A. X ALL-CALY COUNTY

CHURCHLAND SACRED HEART HOSPITAL KIRKERS COMPANY

MARYLAND ALL-CALY X CUMBERLAND 6 E. ROBERT STREET

WRIGHT FROST AUGUST FROST

NO 214-05-0217 SACRED HEART, SECON DR., CUM., NO. 21502

LEFT-VENTRICULAR FAILURE

8 YEARS

EXPERIMENT INTO RIGHT LEC (TERMINAL)

X

X

X

X

X

X

02 GREENE STREET, CUM., NO. 21502

STANFELL FUNERAL HOME, VIRGINIA AVE., CUM., NO. 21502

CHURCHLAND, ALL-CALY COUNTY

2500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07727		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07719	
1. DECEASED-NAME (Type or print)		First Middle Last JOHN WILLIAM GORMER		2a. DATE OF DEATH Month Day Year JUNE 1- 1969	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-22-1907	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (In years last birthday) 62 YRS.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during last year if retired.) Machine Cleaner	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. STREET AND NUMBER 101 WILLS CREEK AVE.,	
14. FATHER'S NAME First Middle Last GEORGE W. GORMER		15. MOTHER'S MAIDEN NAME First Middle Last SARAH E. HITE		12b. KIND OF BUSINESS OR INDUSTRY Brewery	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO		16b. SOCIAL SECURITY NO. 214-05-4729		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus with Coma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Art. C.V. with possible infarction</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/4/64</u> , 19 <u>64</u> , to <u>6/1/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/1/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>T. F. Lusby</u>		22c. DATE SIGNED <u>6/2/69</u>	
22d. PHYSICIAN'S NAME (Type) DR. T. F. LUSBY		22e. ADDRESS 932 NATIONAL HIGHWAY, LAVALE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery,	
24. FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumb. Md.		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.		25a. REC'D BY REGISTRAR JUN 6 1969	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

07719

07719

JOHN	WILLIAM	GOMMER	JUNE	1 - 1939	6:40
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MALE	WHITE	2-22-1907	62		
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MARYLAND	U. S. A.	X	ALLEGANY		
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CUMBERLAND	CENTRAL HOSPITAL	WHEELING	BRIDGE		
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MARYLAND	ALLEGANY	CUMBERLAND	X	101 NILES CREEK AVE.	
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GEORGE	W.	GOMMER	SARAH	E.	HITE
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		2-1-1917		CENTRAL HOSPITAL, CUMBERLAND, MD.	
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	DR. T. F. LUSBY	932 NATIONAL HIGHWAY, LAVALLE, MD.			
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	6/14/69	WASH. STATE UNIVERSITY	CUMBERLAND, ALLEGANY, MD.		
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	JUN 6 1969	102 W. 2nd St. Laval, Md.			
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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4109

19

07728

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07720

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR 5:12 PM		
Kenneth Edgar Gray						June 13, 1969					
3. SEX Male		4. RACE White		5. DATE OF BIRTH January 28, 1910		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
Maryland		USA									
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Memorial Hospital			Fire builder						Manu.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? -YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Allegany		Corriganville						
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost								
Carl E. Gray			Bertha Lowery								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
Yes			217-10-5299		Mrs. Hilda Gray, Corriganville, Md.			21524			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cor. C.A.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute myocardial infarction approx. 1 hr.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u> <u>Few hours</u>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 13, 1969</u> , to <u>June 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John A. Rogers MD</u>						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)						22c. DATE SIGNED					
John A. Rogers MD						June 15 - 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			June 16, 1969		Rest Lawn Memorial		Gardens, La Vale, Md.		Allegany Co.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harvey H. Zeigler, Wyndman, Pa. 1554						DATE JUN 19 1969		<u>John A. Rogers</u>			

05770

05770

1.2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
45M - 1/1/69

07729		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07721			
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH	2b. HOUR	
FRANK		G.	GREEN		6 Month 26 Day 69 Year	1:00 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	WHITE		6/9/88		81 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
W. VA.	USA				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD.		ALLEGANY		WESTERNPORT		13e. STREET AND NUMBER RT 1 -BOX 81	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		
WALTER		GREEN			MAHALIA GREEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address
NO		212 03 5100		SACRED HEART HOSPITAL			-900 SETON DRIVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> 151.9 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							CUMBERLAND, MD. 21502 BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
6-25-69		Upper GI Bleeding		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6-23-69, to 6-26-69, that (I) (we) last saw the deceased alive on 6-26-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
Dr. Matthew L. Kaufman		6-27-69		DR. MATTHEW KAUFMAN			
22e. ADDRESS		22f. ADDRESS					
		912 SETON DRIVE -CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		6-29-69		PHILOS CEMETERY		WESTERNPORT -ALLEGANY - MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FREDLOCK'S FUNERAL HOME -PIEDMONT, WEST VIRGINIA				JUN 30 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR P		
STELLA Y. HARRIS						6	Month	9	Day 69 Year 4:30M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
FEMALE		WHITE		1/20/93		76 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.			ALLEGANY		CUMBERLAND				613 LYNN STREET		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
DANIEL					YOUNG	AGNES			MC MILLEN	YOUNG	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <u>NO</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
			217-10-445B		SACRED HEART HOSPITAL			-900 SETON DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u>											
DUE TO, OR AS A CONSEQUENCE OF											
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), <u>4122</u> <u>HYPERTENSIVE & ARTERIOSCLEROTIC CARDIO-VASCULAR</u>											
DUE TO, OR AS A CONSEQUENCE OF											
DISEASE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
NONE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town			
								County			
								State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5 - 20, 1957</u> , to <u>6 - 9, 1969</u> , that (I) (we) last saw the deceased alive on <u>6 - 9, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Rogers W. Ballin</u>					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-9-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>DR. R. W. BALLIN</u>					22e. ADDRESS <u>62 GREENE ST -CUMBERLAND, MD. 21502</u>						
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)			
<u>BURIAL</u>		<u>6/12/69</u>		<u>Hillcrest Burial Park</u>		<u>Cumberland Allegany Maryland</u>					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>SILCOX-MERRITT FUNERAL SERVICE</u>				<u>404 DECATUR ST.</u>		<u>Charles Judge</u>					
<u>CUMBERLAND, MARYLAND</u>				<u>JUN 16 1969</u>							

29570

CEREBRO-VASCULAR ACCIDENT
HYPERTENSIVE & ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4409

2

1

07731

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07723

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH @ 10:45 A.M. Month Day Year June 18, 1969		2b. HOUR A. M.			
John		Johnson								
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8/2/1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County		Md.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired: Coal Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal Mining				
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Detmold Street		
14. FATHER'S NAME John		First Middle Last Johnson		15. MOTHER'S MAIDEN NAME Elizabeth McMillan		First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-05-5760		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke</u> you.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1969, to June 18, 1969, that (I) (we) last saw the deceased alive on June 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE George M. Simons					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/18/69			
22d. PHYSICIAN'S NAME (Type) George M. Simons					22e. ADDRESS Memorial Hospital, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/21/69		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing A. Md				
24. FUNERAL DIRECTOR George Eichhorn					ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

07731

STATEMENT OF DEATH

07731

John
Male
Age 70
Married
Born [illegible]
Residence [illegible]
Cause of Death [illegible]
Burial [illegible]
John
Male
Age 70
Married
Born [illegible]
Residence [illegible]
Cause of Death [illegible]
Burial [illegible]

George
Male
Age 70
Married
Born [illegible]
Residence [illegible]
Cause of Death [illegible]
Burial [illegible]
George
Male
Age 70
Married
Born [illegible]
Residence [illegible]
Cause of Death [illegible]
Burial [illegible]

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07732				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07724											
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR					
JESSE				C		JUDY		8 Month 7 day 69				9:35AM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.									
MALE		WHITE		10-31-15		53 YRS.		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH										Md.			
W. VIRGINIA		U.S.A.				ALLEGANY													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND				MEMORIAL HOSPITAL				UNEMPLOYED											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
MARYLAND				ALLEGANY		CUMBERLAND				411 PIEDMONT AVENUE									
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First		Middle		Last	
MICHAEL				S		JUDY				VIRGINIA						OURS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT				Address					
No										MEMORIAL HOSPITAL				CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Carcinoma, left lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>with metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>May 23, 1969</u> , to <u>June 7, 1969</u> , that (I) (we) lost saw the deceased alive on <u>June 7, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Calvin G. Hadidian</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>6/8/69</u>											
22d. PHYSICIAN'S NAME (Type) DR. CALVIN HADIDIAN				22e. ADDRESS CUMBERLAND, MD.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
Burial				June 9, 1969		Mt. Herman Cemetery				Cumberland, Allegany, Md.									
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
James F. Scarpelli, Cumberland, Md.								JUN 11 1969		Charles Judge									

07735

07734

JESSIE C JULY 1932

MALE WHITE 10-31-12

W. VIRGINIA U.S.A. ALLEGANY

CUMBERLAND MEMORIAL HOSPITAL EMPLOYED

ALLEGANY CUMBERLAND X 411 PLEASANT AVENUE

MICHAEL S JULY VIRGINIA

MEMORIAL HOSPITAL CUMBERLAND, MD.

SP. CALVIN RABBITAN CUMBERLAND, MD.

James J. Seaver, Jr., Cumberland, Md.

James J. Seaver, Jr., Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15-34
45M - 1-7-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07738									
07725									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Mary Margaret Kabosky						June 15, 1969		P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		1/1/1911		58 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				Allegany County		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Allegany County Infirmary		Office: Sells Co., Inc.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegany		Cumberland				16 Pennsylvania Ave.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Thomas M. Lillard			Hannah Hogan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT P. O. Box 599, Address Cumberland, Md. Allegany County Infirmary records.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebrovascular Accident									
4369 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Jcs Arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 5, 1968, to June 15, 1969, that (I) (we) lost saw the deceased alive on June 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
George M. Simons					6/17/69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
George M. Simons					Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMAINS		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 18, 1969		St. Mary's Cemetery		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.					JUN 24 1969		Allegany Judge		

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June 15

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First GEORGE,		Middle F.		Last KEARCHNER		2a. DATE OF DEATH Month 06 Day 23 Year 69			2b. HOUR A.M. 12:02
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 02-18-22			6. AGE (In years last birthday) 47 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY, Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) JANITOR KELLY SPRINGFIELD TIRE CO.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER UPPER HOMEWOOD ADD., BOX 199		
14. FATHER'S NAME First LORANZE			Middle KEARCHNER			Last (CATACH) EFFIE			15. MOTHER'S MAIDEN NAME First KEARCHNER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown YES			16b. SOCIAL SECURITY NO. 220-03-7617		17. INFORMANT Address MD. 21502						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary heart failure 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) coronary sclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 3 years 3 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5-22- , 19 69 , to 6-22- , 19 69 , that (I) (we) last saw the deceased alive on 6-22- , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. Brings								DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-23-69	
22d. PHYSICIAN'S NAME (Type) L. BRINGS, M.D.								22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/25/69		23c. NAME OF CEMETERY OR CREMATORY Wiltcrest Burial Ph.			23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.				
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.				25a. REC'D BY REGISTRAR DATE JUN 25 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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GEORGE, F. KEE CHINESE

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WHITE 02-1-52

HAYLAND U.S.A. ALLIANCE COUNTY

SACRED HEART HOSPITAL JANITOR-REALLY SPTACIFIED

HAYLAND ALLIANCE CAMPBELLS UNITED HINDOON AND BOX

LEONARD KEE CHINESE (CATHOLIC) BIRTH

YES 000-02-2612 SACRED HEART HOSPITAL, 900 SECON ST., N.Y.

L. BRINGS, N.Y. 22 GREENE ST., CAMPBELLS, N.Y. 250

5719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07735

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07727

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>06</u> Day <u>14</u> Year <u>69</u>		2b. HOUR M	
JAMES		PATRICK		KENNEY JR.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 04-24-12		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md.
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PIPE FITTER		12b. KIND OF BUSINESS OR INDUSTRY PPG IND.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death, if not) MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 61 W. MAIN ST.,
14. FATHER'S NAME First JAMES		Middle PATRICK		Last KENNEY SR.		15. MOTHER'S MAIDEN NAME First MARY		15. MOTHER'S MAIDEN NAME Middle E.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <u>YES</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-01-8833		17. INFORMANT HOSPITAL REC., 900 SETON DR., CUMBERLAND, MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTISEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC COMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CIRRHOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WKS 5 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>HEMOCHROMATOSIS</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>69</u> , to <u>6-14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>L. Michael Glick</u>		DEGREE L. MICHAEL GLICK MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-15-69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 912 SETON DR., CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/17/69		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.		
24. FUNERAL DIRECTOR HAVER SOWERS, 60 W. MAIN ST., FROSTBURG, MD. 21502		25a. REC'D BY REGISTRAR DATE JUN 23 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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JAMES

PATRICK

KENNEY JR.

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WHITE

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MASSACHUSETTS

USA

ALLEGANY

CLIMBERLAND

SACRED HEART HOSPITAL

THE FIFTH

PTG IND.

MASSACHUSETTS

ALLEGANY FROSTBURG

61 W. MAIN ST.

JAMES

PATRICK

KENNEY SR.

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14

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YES

215-01-10-22

HOSPITAL NO. 000 SECTOR OF CLIMBERLAND, MA

L. MICHAEL CLICK RD

012 SECTOR OF CLIMBERLAND, MA 21502

HARPER 2 W. MAIN ST., FROSTBURG, MA 21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07736

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07728

1. DECEASED-NAME (Type or print) First Middle Last Herald Myers Lambert			2a. DATE OF DEATH Month Day Year June 18 1969		2b. HOUR M
3. SEX Male	4. RACE White		5. DATE OF BIRTH Dec. 13, 1917		6. AGE (In years last birthday) 51 YRS. MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Allegany			Md.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) B.O.A. Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Division Manager	
12b. KIND OF BUSINESS OR INDUSTRY Retail Store					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Wiley Ford	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER None			
14. FATHER'S NAME First Middle Last E.A. Lambert			15. MOTHER'S MAIDEN NAME First Middle Last Laura Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		(If yes give war or dates of service) War II		16b. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lucy Lambert, Wiley Ford, W.Va.-Wife		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cordial Failure 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A.S. as Hypertensive Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus, severe					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years 17 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11 June 1965 , to 10 October 1968 , that (I) (we) last saw the deceased alive on 10 October 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Alfred Van Ormer				22c. DATE SIGNED 20 June 1969	
22d. PHYSICIAN'S NAME (Type) Dr. W. A. Van Ormer, M.D.				22e. ADDRESS 122 S. Centre St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR JUN 24 1969	
25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

485-X

07737

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07729

1. DECEASED-NAME (Type or print) WALKER R. LILLER			2a. DATE OF DEATH 6 Month 19 Day 69 Year		2b. HOUR 8:30 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 12-24-95		6. AGE (In years lost birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) W. VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED FROM KELLY SPRINGFIELD	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last OLLIE LILLER		15. MOTHER'S MAIDEN NAME First Middle Last (TASKER) MARY LILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-10-6792		17. INFORMANT HOSPITAL RECORDS Address 900 SETON DR. CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Asthmatic Bronchitis					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 5/24 , 19 69 , to 6-19 , 19 69 , that (I) (we) lost saw the deceased alive on 6/19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Spiggle md			DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) WAYNE D SPIGGLE, MD.			22e. ADDRESS 912 SETON DRIVE CUMB., MD. 21502		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 22, 1969	23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR KIGHT FUNERAL HOME		ADDRESS 509 DECATUR ST. CUMBERLAND, MD.		25a. REC'D BY REGISTRAR J. Charles Judge DATE JUN 23 1969	

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FOR STATE
HEALTH DEPT.

07738

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07730

1. DECEASED-NAME (Type or Print)			First WILLIAM			Middle JOSEPH			Last LIPPOLD			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> JUNE 2 19 69			2b. HOUR 930AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEB 24 1894		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year JUNE 2 19 69			2d. HOUR 930AM		
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) MEMORIAL HOSPITAL-DOA				12a. USUAL OCCUPATION (Kind of work done during 1 year preceding death) RETIRED PLANO TUNER				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN CUMBERLAND				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 122 BEDFORD STREET			
14. FATHER'S NAME First Middle Last JOHN D. LIPPOLD				15. MOTHER'S MAIDEN NAME First Middle Last MARGARET #NAME# COSGROVE													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES				16b. SOCIAL SECURITY NO. (If yes, give year or dates of service) WMI 213-12-9115				17. INFORMANT Wm J. Lippold, Jr				ADDRESS Box 902 Leesburg, Va					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED JUNE 2, 1969					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 6/4/69				23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery				23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland					
24. FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE				404 DECATUR STREET CUMBERLAND				25a. REC'D BY REGISTRAR MD JUN 5 1969				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 78. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FIGURE 1. The effect of the concentration of the solution on the rate of the reaction.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 4 Film 413 6/25/69 kk
Item 5 Film 413 6/20/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07731

1. DECEASED NAME 07739 FLORENCE		First Middle Last D LYTLE		2a. DATE OF DEATH Month Day Year 6 16 69		2b. HOUR 5:50AM	
3. SEX FEMALE		4. RACE WHITE Black		5. DATE OF BIRTH 12-20-25 1924		6. AGE (In years last birthday) 44 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last JOSEPH E. SIMMS		15. MOTHER'S MAIDEN NAME First Middle Last MANILLA HAWKINS		13e. STREET AND NUMBER 1513 ROSEWOOD AVENUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized peritonitis DUE TO, OR AS A CONSEQUENCE OF (c) perforated gastric ulcer PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
19a. DATE OF OPERATION 6-13-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated ulcer		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6-13, 1969 , to 6-16, 1969 , that (I) (we) last saw the deceased alive on 6/16 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Andrew Stasko				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/16/69	
22d. PHYSICIAN'S NAME (Type) DR. C. BRINSFIELD				22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/18/69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Alleg. Md.	
24. FUNERAL DIRECTOR John J. Hater, Jr.				25a. REC'D BY REGISTRAR DATE 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

01731

01731

REFERENCE

1971

WHITE JACK 12-20-1971

U.S.A.

WESTLAND NATIONAL HOSPITAL

ALLEGANY COUNTY, N.Y.

JOSEPH E. SHAW

MAILED

NATIONAL HOSPITAL, WESTLAND, N.Y.

DR. C. DUNN

WESTLAND, N.Y.

404 W

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First NELLIE	Middle GRACE	Last MACK	2a. DATE OF DEATH Month 06 Day 03 Year 69		2b. HOUR 4:35PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5-16-77		6. AGE (In years and birthday) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY			Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital country, state, and address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE				
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. CITY OR TOWN CUMBERLAND		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 408 WALNUT STREET				
14. FATHER'S NAME First HENRY		Middle HIGGINS		Last ELIZABETH		15. MOTHER'S MAIDEN NAME First ELIZABETH		Middle HUDSON		Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-54-6336		17. INFORMANT HOSPITAL REC., 900 SETON DR., CUMB., MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>404x Congestive heart failure, c pulmonary edema, and hepatomegaly</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive and arteriosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular - renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Central arteriosclerosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>5-21-1969</u> , to <u>6-3-1969</u> , that (I) (we) last saw the deceased alive on <u>5 June 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>S.G. Weisman MD</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4 June 69</u>			
22d. PHYSICIAN'S NAME (Type) S.G. WEISMAN MD					22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE <u>6/6/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u>		23d. LOCATION (City or Town) <u>Cumberland Allegany</u>		(County)		(State)
24. FUNERAL DIRECTOR STEINS FUNERAL HOME, CUMBERLAND, MD. 21502					25a. REC'D BY REGISTRAR <u>JUN 9 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

07370

07370

NAME: [REDACTED] PLACE: [REDACTED] DOB: [REDACTED]

SEX: [REDACTED] RACE: [REDACTED] HT: [REDACTED] WT: [REDACTED]

EDUCATION: [REDACTED] OCCUPATION: [REDACTED]

RELIGION: [REDACTED] POLITICAL: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

ALLEGY: [REDACTED] ALLEGY: [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07741

CERTIFICATE OF DEATH

07733

1. DECEASED-NAME (Type or print) First Middle Last MARTIN LOUIS I.			2a. DATE OF DEATH 6 Month 6 Day 69 Year		2b. HOUR 11:45 M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9/8/07	
6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of last year) RUBBER WORKER	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY	
13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1 -BOX 57	
14. FATHER'S NAME First Middle Last WILLIAM MARTIN		15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH WATKINS MARTIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, NO (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-10-1243		17. INFORMANT Address SACRED HEART HOSPITAL -900 SETON DRIVE CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 011.4 Miliary tuberculosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HRS. Unknown					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Portal vein thrombosis, B Intertronic crd.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) ✓			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) ✓		21f. LOCATION Street or R.F.D. No. City or Town County State ✓	
22a. I certify that (I) (this hospital) attended the deceased from 5-18 , 19 69 , to 6-6 , 19 69 , that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Martin Luther King Jr.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-10-69	
22d. PHYSICIAN'S NAME (Type) DR. M. ROTHSTEIN		22e. ADDRESS 48 BROADWAY -FROSTBURG, MARYLAND 21532			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-9-69		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE'S CEMETERY	
23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.		24. FUNERAL DIRECTOR ADDRESS DURST FUNERAL HOME -57 FROST AVENUE FROSTBURG, MARYLAND 21532			
25a. RECEIVED BY REGISTRAR JUN 12 1969		25b. RECEIVED BY STATE HEALTH DEPT. ✓			

WEST FUNERAL HOME - 52 FIRST AVENUE
FREDRICK, MARYLAND 21222

DR. H. ROBINSON - 400 W. 1ST AVENUE, FREDRICK, MARYLAND 21222

NO. 1
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 2
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 3
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 4
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 5
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 6
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 7
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 8
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 9
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.
NO. 10
WILLIAM WATSON
ELIZABETH WATSON
SACRED HEART HOSPITAL - 5200 SEVENTH AVE.
CUMBERLAND, MD.

DATE: 11-11-52
TIME: 11:45
NAME: WATSON
ADDRESS: 1012
CITY: FREDRICK
STATE: MARYLAND
ZIP: 21222

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER:
 necessary, please execute the certificate of death and return it to the funeral director. Page 4 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

ers after death.

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VR A15ME (5)
10M REV. 1/68

June 12, 1969
Comberland, Md.

in Vaile, Md. Also any

Resting Gardens

6-11-1969

Bar. 1

June 11, 1969, Comberland, Md.

Dr. Benedict Bicknell, N.D.

x

x

x

x

x

Constitutional Heart Disease

Acute Rheumaty Edema

1 Hour

Mr. Carl Turner, Wiley Ford, W. Va.

none

no

Linda A. Turner

he Donald

Terry Gairland

W. Va.

Mineral

Wiley Ford

x

500 Greene St.

none

Comberland

USA

MD.

March 28, 1969

White

Male

1

June 12

June 12, 1969

he Donald

Gairland

Terry

June 12, 1969

07718

07734

4/11/9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07743

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 501 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07735

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Joseph I. McGregor						6	Month	9	Day	1969	11-35
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		White		2/2/1912			57 YRS.		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
MD.		USA.					Allegheny				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Frostburg			Miners Hospital			Trucker-Self-employed					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.			Allegheny		Lonaconing				Jackson Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Robert McGregor			Catherine Fitzpatrick								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						Mrs. Buna McGregor, Lonaconing, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Ischemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pulmonary Fibrosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 9, 1969</u> , to <u>June 9, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 9, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE <u>L.R. Miles, Jr.</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6.10.69</u>			
22d. PHYSICIAN'S NAME (Type) <u>L.R. MILES, JR.</u>						22e. ADDRESS <u>LONA CONING, MD. 21539</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)
Burial		6/12/1969		St. Marys Cemetery			Lonaconing, Md.				
24. FUNERAL DIRECTOR <u>GEORGE EICHHORN</u>						ADDRESS <u>Lonaconing, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 11 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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1621
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

1621
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 11-89

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
077744					077736						
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
WYANT		C.		MESSMAN		JUNE 17 1969		2:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		JUNE 4, 1904		65 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
MARYLAND		USA				ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL						JEWELRY STORE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND				803 SHRIVER AVENUE			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
WYANT		C		MESSMAN		(SELL)		MARY		MESSMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		214-05-4272		HOSPITAL RECORDS, 900 SETON DRIVE, CUMB., MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia of the lungs with metastases to the brain</i> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 2 hrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1960, to 6/17, 1969, that (I) (we) last saw the deceased alive on 6/15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>S.G. Weisman</i>		22c. DATE SIGNED 6/17/69		22d. PHYSICIAN'S NAME (Type) S.G. WEISMAN, M.D.		22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/19/69		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		23d. LOCATION (City or Town) Cumberland Allegany (County) (State)					
24. FUNERAL DIRECTOR <i>Stains</i>		25a. REC'D BY REGISTRAR JUN 20 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
STEINS FUNERAL HOME		CUMBERLAND, MD.									

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1969 17 JUNE

HESSMAN

C.

1969

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JUNE 17, 1969

WHITE

1969

ALLEGANY

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ALLEGANY

SACRED HEART HOSPITAL

CLINICAL

303 S. 11TH AVENUE

ALLEGANY CLINICAL

ALLEGANY

HESSMAN

1969

(SELF)

HESSMAN

C

1969

NO

214-05-4725 HOSPITAL RECORDS, 100 S. 11TH AVENUE, CLINICAL, ALLEGANY

29 GREENE ST., CLINICAL, NO. 21502

S.E. WEISMAN, M.D.

STEIN'S FUNERAL HOME, CLINICAL, NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07745		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07737							
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR				
First		Middle		Last		Month		Day		Year		HOUR	
James		William		Miller		June		8		1969		7:25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White		3/27/1880			89 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
W.Va.		U.S.A.					Allegany, Cumberland Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			Sylvan Retreat			Plumber			Self				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.			Allegany			Cumberland				523 Valley Street			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Charles			Miller			Mary Blackburn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT							
Unk			220-16-6894			Phylliss Rossworm, 611 Shriver Ave Cumberland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cerebro-vascular accident													
4369 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) Generalized arteriosclerosis													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/9/68, 19, to 6/8, 1969, that (I) (we) last saw the deceased alive on 6/11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE			22c. DATE SIGNED				
George M. Simons						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			6/10/69				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
George M. Simons						Cumberland Md							
23a. BURIAL, CREMATION, REINTERMENT			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial (Type)			6/11/1969			Zion Memorial Park			Cumberland Alleg Md				
24. FUNERAL DIRECTOR						25a. REG'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
John H. Haler, Jr. 230 Balto. Ave. Cumberland Md						JUN 12 1969			Charles Judge				

07737

RECEIVED 10 JAN 1961

07737



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

1

07746

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07738

1. DECEASED-NAME (Type or print)			First William	Middle A.	Last Miller	2a. DATE OF DEATH Month 6 Day 5 Year 69			2b. HOUR P. M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/19/1884		6. AGE (In years last birthday) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegheny County Md.							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegheny County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Brakeman for P. R.			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegheny		13c. CITY OR TOWN Ellerslie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Ellerslie, Maryland			
14. FATHER'S NAME First Samuel			Middle Miller			15. MOTHER'S MAIDEN NAME First Ida			Middle Miller			Last Miller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO. 716-10-5699		17. INFORMANT P. O. Box 599, Cumberland, Md. Allegheny County Infirmary records.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Atrial Insufficiency 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Chr. A2HD. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH approx 4 yrs. many years many years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) Coronary A.S. with mental deterioration.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1968 , to June 5, 1969 , that (I) (we) lost saw the deceased alive on June 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John A. Tepper						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) John A. Tepper MD						22c. DATE SIGNED 6-6-69							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Cooks Mills Cemetery			23d. LOCATION (City or Town) (County) (State) Hyndman Rd., Bedford Pa						
24. FUNERAL DIRECTOR Harvey N. Fagler				ADDRESS Hyndman, Pa		25a. RECEIVED BY REGISTRAR JUN 10 1969			25b. REGISTRAR'S SIGNATURE Harvey N. Fagler				

3170

03736

Item 23 Film 415
8/7/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07747

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07739

FOR STATE
HEALTH DEPT.

1. DECEASED-NAME (Type or Print)			First James			Middle Richard			Last Moore			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year June 13 1969			2b. HOUR 1:15 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 4, 1929		6. AGE (In years last birthday) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year June 13 1969			2d. HOUR 1:15 PM		
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial Hospital - Yardmaster						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Allegany				13c. CITY OR TOWN La Vale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 5, Winchester Road					
14. FATHER'S NAME First Middle Last Russell F. Moore						15. MOTHER'S MAIDEN NAME First Middle Last Violet Beall											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) Korean				17. INFORMANT ADDRESS Wife Mrs. Patricia Moore, Rt. 5 Winchester Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED June 13, 1969					
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Rt. 9, Cumberland									
23a. BURIAL, CREMATION, or other (Specify) Burial				23b. DATE June 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Porter Cemetery				23d. LOCATION (City or town, county) (State) Near Ellerslie, Md. Pa.							
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.								25a. REC'D BY REGISTRAR DATE JUN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

James L. Campbell, Cumberland, Md.

June 10, 1959, Fort Detrick

Dr. Benedict Kivric, M.D.

June 11, 1959
H.S. Campbell

Fort All Hall, Md.

Coronary Sclerosis

Coronary Occlusion

Yes

Yes, Arteriosclerosis, H.S. Campbell, Md.

Russell

W. Moore

Victor Seal

Alimony in Vile

X House 2, Winchester Road

Corporation

D.O.A. Memorial Hospital - Baltimore

Married

Yes

Alimony

Wife

Dec. 1, 1959

June 11

11

June 11, 1959

0747

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0747

2509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Anita Margaret Moreland						2a. DATE OF DEATH June Month 6 th Day 69 Year		2b. HOUR 635AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11-25-1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Mo. St. Louis		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Cumberland, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife & Fmr. Prop.		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 318 Prince George St.	
14. FATHER'S NAME First Middle Last Joseph Versen				15. MOTHER'S MAIDEN NAME First Middle Last Josephine Harleess						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 215-20-7266		17. INFORMANT Mr. Harry Moreland				Address Cumb. Md. 318 Prince George St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic long-term heart failure</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S. as Hypertensive Cardiovascular Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Overweight Chronic Cholelithiasis & Cholecystitis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1946</u> , 19 <u> </u> , to <u>6 June</u> , 19 <u>69</u> , that (I) (was) lost saw the deceased alive on <u>5 June</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) <u>(did)</u> (did not) view the body after death.										
22b. SIGNATURE <u>W. A. Van Ormer, M.D.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6 June 69</u>				
22d. PHYSICIAN'S NAME (Type) <u>W. A. VanOrmer, M. D.</u>				22e. ADDRESS <u>122 So. Centre St. Cumberland, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>6/7/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>				
24. FUNERAL DIRECTOR <u>H. Wayne George</u>				ADDRESS <u>202 Greene St. Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 9 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. Judge</u>		

07748

RECORDS OF DEATH

07748

213-20-1254 Mr. Robert Leonard 218 Prince George St.

112 St. George St. Vancouver, B.C.

8/7/59 Fort Vancouver District Registrar

11 Prince George St. Vancouver, B.C.

07749

CERTIFICATE OF DEATH

07741

1. DECEASED-NAME (Type or print) <u>CLARENCE - NICKLOW</u>			2a. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1969</u>			2b. HOUR <u>10:30</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>April 14, 1887</u>		6. AGE (In years last birthday) <u>82</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Penn.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Allegany</u> Md.	
10. CITY OR TOWN OF DEATH <u>Frostburg</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Tisdale St.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Owner</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Allegany</u>		13c. CITY OR TOWN <u>Frostburg</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>Tisdale St.</u>		14. FATHER'S NAME First <u>Edward</u> Middle <u>Nicklow</u> Last <u>Susan</u>		15. MOTHER'S MAIDEN NAME First <u>Susan</u> Middle <u>Humperson</u> Last <u>Humperson</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>212-32-8894</u>		17. INFORMANT <u>Louise Seegie</u>		Address <u>Frostburg Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HCUO arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>emphysema</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Year 1</u> <u>Years.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> , 19 <u>69</u> , to <u>6/4</u> , 19 <u>69</u> , that (I) was last saw the deceased alive on <u>6/4/69</u> 19 <u>69</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.							
22b. SIGNATURE <u>John B. Davis</u> , DEGREE <u>M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/4/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>				22e. ADDRESS <u>2 Broadway, Frostburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6/6/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zion Luth. Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Accident Md.</u>	
24. FUNERAL DIRECTOR <u>Paul D. Mannich</u>				ADDRESS <u>Catonsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 11 1969</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14770

TECHNICAL DEPT

14770

FOR STATE
HEALTH DEPT.

07750

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07742

1. DECEASED-NAME (Type or Print)		First R.		Middle ANNAN		Last PRICE		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> June 6, 69		2b. HOUR 10aM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEB. 11, 1897		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year June 6, 1969 19	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Hospital-DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED RAILROADER		12b. KIND OF BUSINESS OR INDUSTRY WM R. R.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY		13c. CITY OR TOWN ECKHART		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last OWEN PRICE				15. MOTHER'S MAIDEN NAME First Middle Last SARAH CLOSE				17. INFORMANT ADDRESS 5 RICHARD WAY WILLIAM R. PRICE, LA VALE, MD. 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16b. SOCIAL SECURITY NO. WW 1							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, GENERALIZED DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1519 (b) CARCINOMA OF STOMACH, PRIMARY DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year 18 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION June 18, 1969				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Carcinoma of Stomach				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				June 6, 1969			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) ALLEGANY			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 9, 1969		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d. LOCATION (City or Town) (County) (State) Eckhart, Md.					
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR DATE JUN 12 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07751		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07743	
1. DECEASED-NAME (Type or print) First Middle Last JAMES R. PUFFENBARGER			2a. DATE OF DEATH Month 06 Day 24 Year 69		2b. HOUR 1:30 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 10-03-90		6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during last year of life, even if retired.) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.	13b. CITY OR TOWN Mineral	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER WILEY FORD, W. VA. 26767		
14. FATHER'S NAME First Middle Last ANDY PUFFENBARGER		15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH EYE PUFFENBARGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 705-10-8401		17. INFORMANT Address SACRED HEART, SETON DR., CUMB., MD. 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Decompensation DUE TO, OR AS A CONSEQUENCE OF 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Pneumothorax					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs unk. unk.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease, Atrial Fibrillation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/9, 1969 , to 6/24, 1969 , that (I) (we) lost the deceased alive on 6/23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J.A. PAGAN, M.D.		22c. DATE SIGNED 6/24/69		22d. PHYSICIAN'S NAME (Type) J.A. PAGAN, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 26, 1969		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		23e. REC'D BY REGISTRAR JUN 27 1969		23f. REGISTRAR'S SIGNATURE Charles J. J...	
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME 108 VIRGINIA AVE., CUMB.					

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SCARBELL, R. MEDAL HOME - 103 VI GINIA AVE., CONG.,

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07752

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6, Film G414 7/7 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07744

1. DECEASED-NAME (Type or Print)			First Middle Lost			2a. DATE KNOWN OF DEATH			XX Month Day Year			2b. HOUR					
Florin Rudolph Raines						June 27, 1969			5:30p								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD					
Male		White		7-7-1900		69 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH					
W. Va.		U.S.A.						<input checked="" type="checkbox"/>				Allegany Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland				Memorial Hospital				Self Emp. trucker				Hauling					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?					
West Virginia				Hampshire				Romney				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13e. STREET AND NUMBER				14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Box 81				Albert V. Raines				Chloe Smith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown))				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
no				217-10-6715				Florin D. Raines				Springfield, W. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:												1 Hour					
IMMEDIATE CAUSE (a) 4109																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) Coronary Occlusion																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) Coronary Sclerosis												---					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
				HOUR A.M. P.M. 19													
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town		County		State	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>																	
AT WORK <input type="checkbox"/>																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				Benedict Skitarellic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				Benedict Skitarellic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				June 27, 1969					
								ADDRESS (Street, city, town, or county)				Cumberland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				6-30-69				Indian Mound Cemetery				Romney, Hampshire W. Va.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
William G. Kight				Cumberland, Md.				JUL 2 1969				K. Charles Judge					

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07753

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07745

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
FREDERICK			ANON			RANKIN			Month Day Year		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
MALE			WHITE			NOV. 23, 1907			61 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD		
MARYLAND			U.S.A.						Month Day Year		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
FROSTBURG			Miners Hospital--DOA			LABORER			BRICKYARD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MARYLAND			ALLEGANY			BORDEN MINES			NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
ALEX			RANKIN			CATHERINE			McCREADY		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
BOX 305, FROSTBURG, MD.			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate Poisoning</u>			1-2 Hours					
			(b) <u>(Self Administered)</u>			"					
			(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M.			19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 18, 1969								
			ADDRESS (Street, city, town, or county)						ALLEGANY		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			6/21/69			FROSTBURG MEMORIAL PARK			FROSTBURG, ALLEGANY, MD.		
24a. FUNERAL DIRECTOR			24b. ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Marilyn M. Sowers			HOME, 60 W. MAIN, FROSTBURG			JUN 30 1969			Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07754		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07746	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
LABON			C.	REXRODE	06 Month 22 Day 69 Year		3:50A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
MALE		WHITE		9-13-1885		83 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		UNITED STATES				ALLEGANY CO. Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND, MD.		MEMORIAL HOSPITAL		Real Estate Broker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		ALLEGANY		CUMBERLAND		<input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
WILLIAM				REXRODE	ELIZA		JORDON
16a. WAS DECEASED EVER IN U.S. ARMY FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO		159-14-1581		MEMORIAL HOSPITAL		CUMB., MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Refractory Heart Failure</u>							days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <u>Chronic and Acute Cor Pulmonale</u>							
(c) <u>Chronic Bronchitis, Pulmonary Emphysema and Pulmonary Fibrosis-Advanced</u>							years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<u>Generalized Arteriosclerosis with Cerebral Insufficiency</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1969</u> , to <u>June 22, 1969</u> , that (I) (we) last saw the deceased alive on <u>6-22-69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		OEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED	
						6-23-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
XEROXIANES 133 Va. Ave.,		CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6/25/69		Pleasant Grove Cemetery		Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service, Cumberland, Md		21502		JUN 25 1969			

07748

07750

08 23 09 3:30A

TEXAS

C.

WASH

13

1-17-1881

WHITE

MALE

ALLEGANY CO.

UNITED STATES

WEST VIRGINIA

HOSPITAL

CUNNINGHAM, W.

ALLEGANY CO.

ALLEGANY

MARYLAND

TEXAS

MARYLAND

1-17-1881 HOSPITAL

CUNNINGHAM, W.

HOSPITAL

ALLEGANY CO. and State of Virginia

ALLEGANY CO. and State of Virginia

ALLEGANY CO. and State of Virginia

(1881)

ALLEGANY CO. and State of Virginia

X

Time 2:30 PM

1, 1881

0-12-82

0-12-82

X

CUNNINGHAM, W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
ANNA M. RICKER						6 Month 4 Day 69 Year		7:50 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
FEMALE		WHITE		7/6/95		73 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life or if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			ALLEGANY		LA VALE				1049 NATIONAL HIGHWAY	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
TERRANCE WOODS			CATHERINE GILLESPIE WOODS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO					SACRED HEART HOSPITAL		900 SETON DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>pneumonia</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>hypertension</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> , 19 <u>64</u> , to <u>6-4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
L. Brings MD						6-5-69				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
DR. LEWIS BRINGS				57 GREENE ST., CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/7/69		Sunset Memo. Pk.		Cumberland Allegany Md				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
STEIN'S FUNERAL HOME		-117 FREDERICK STREET		DATE JUN 9 1969		Signature				
CUMBERLAND, MARYLAND 21502										

07756

CERTIFICATE OF DEATH

07748

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
WILLIAM			H.		ROBERTSON	JUNE Month 19 Day 1969			1:12A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		10-4-93		75 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD.			ALLEGANY		LONA CONING						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JOSEPH					ROBERTSON	ETHEL			L.		VAUGH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT					
					164-10-3091	MEMORIAL HOSP., CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Cardiac failure</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S. Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic lung disease, bronchitis, fibron emphysem,</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u> <u>5 years.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia & hemiparesis. known since 1963</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
15 Jan 69		Hypertension, acute stroke			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>14 Jan</u> , 19 <u>69</u> , to <u>19 Jan</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>18 Jan. 69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. Alfred Van Opmer M.D.</u>					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>19 Jan 69</u>		
22d. PHYSICIAN'S NAME (Type) DR. VAN OPMER					22e. ADDRESS CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/21/1969		Laurel Hill Cemetery		Moscow, Md.					
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
EICHORN FUNERAL HOME, LONA CONING, MD.					DATE JUN 23 1969		<u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07750

07750

WILLIAM H. ROBERTSON JUNE 19 1969 1:13A

WIFE WHITE 10-4-93

ALLIANCE USA

GENERAL HOSPITAL

ALLIANCE COMMANDING

JOSEPH ROBERTSON STEEL L. VAUGHN

10-10-93 GENERAL HOSPITAL, CLEVELAND, OH.

DR. VAN COTT CLEVELAND, OH.

DR. VAN COTT CLEVELAND, OH.

DR. VAN COTT CLEVELAND, OH.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07757

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07749

1. DECEASED-NAME (Type or Print)		First LESTER	Middle ELWOOD	Last SINES	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month June Day 13 , Year 1969		2b. HOUR 6:45 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 7, 1905		6. AGE (In years last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month June Day 13 , Year 1969
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany	
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D. O. A. Sacred Heart			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Custodian		12b. KIND OF BUSINESS OR INDUSTRY Laboratory
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cresaptown,		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Henry Middle B. Last Sines		15. MOTHER'S MAIDEN NAME First Harriet Middle -- Last Mankis		13e. STREET AND NUMBER Craddock Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) No.		16b. SOCIAL SECURITY NO. 220-10-2804		17. INFORMANT Mrs. Iva Mae Sines, Cresaptown, Md. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ----							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		June 13, 1969	
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Rt. # 9	
				ADDRESS (Street, city, town, or county)		Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/16/69		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George, Cumberland, Md. 21502				ADDRESS		25a. REC'D BY REGISTRAR JUN 17 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

02757

07740

TEST	ELONG	SIZE	DATE
100	100	100	June 13, 1952
100	100	100	June 15, 1952
100	100	100	June 18, 1952
100	100	100	June 21, 1952
100	100	100	June 24, 1952
100	100	100	June 27, 1952
100	100	100	June 30, 1952
100	100	100	July 3, 1952
100	100	100	July 6, 1952
100	100	100	July 9, 1952
100	100	100	July 12, 1952
100	100	100	July 15, 1952
100	100	100	July 18, 1952
100	100	100	July 21, 1952
100	100	100	July 24, 1952
100	100	100	July 27, 1952
100	100	100	July 30, 1952
100	100	100	August 2, 1952
100	100	100	August 5, 1952
100	100	100	August 8, 1952
100	100	100	August 11, 1952
100	100	100	August 14, 1952
100	100	100	August 17, 1952
100	100	100	August 20, 1952
100	100	100	August 23, 1952
100	100	100	August 26, 1952
100	100	100	August 29, 1952
100	100	100	September 1, 1952
100	100	100	September 4, 1952
100	100	100	September 7, 1952
100	100	100	September 10, 1952
100	100	100	September 13, 1952
100	100	100	September 16, 1952
100	100	100	September 19, 1952
100	100	100	September 22, 1952
100	100	100	September 25, 1952
100	100	100	September 28, 1952
100	100	100	September 30, 1952
100	100	100	October 3, 1952
100	100	100	October 6, 1952
100	100	100	October 9, 1952
100	100	100	October 12, 1952
100	100	100	October 15, 1952
100	100	100	October 18, 1952
100	100	100	October 21, 1952
100	100	100	October 24, 1952
100	100	100	October 27, 1952
100	100	100	October 30, 1952
100	100	100	November 2, 1952
100	100	100	November 5, 1952
100	100	100	November 8, 1952
100	100	100	November 11, 1952
100	100	100	November 14, 1952
100	100	100	November 17, 1952
100	100	100	November 20, 1952
100	100	100	November 23, 1952
100	100	100	November 26, 1952
100	100	100	November 29, 1952
100	100	100	December 2, 1952
100	100	100	December 5, 1952
100	100	100	December 8, 1952
100	100	100	December 11, 1952
100	100	100	December 14, 1952
100	100	100	December 17, 1952
100	100	100	December 20, 1952
100	100	100	December 23, 1952
100	100	100	December 26, 1952
100	100	100	December 29, 1952
100	100	100	December 31, 1952

180X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151-1
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07758					07750				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
HELEN A. SKIDMORE					6 Month 13 Day 69 Year			4:30PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		12-19-24		44 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND,		SACRED HEART HOSPITAL				HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		FROSTBURG		25 FROST VILLAGE			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
JOHN JONES			CARRIE JONES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO			214-24-0982		HOSPITAL RECORDS		900 SETON DR. CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Uremia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Carcinoma of Uterine Cervix</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>4 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>69</u> , to <u>6-13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
<u>L. M. GLOCK</u>		<u>6-13-69</u>		<u>L. M. GLOCK</u>		<u>BRADDOCK MED GROUP - CUMBERLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>6/16/1969</u>		<u>Mt. View Cemetery</u>		<u>Moscow, Md.</u>			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>EICHORN FUNERAL SERVICE</u>		<u>JUN 17 1969</u>		<u>Charles Judge</u>					

03750

03750

HELEN A. SKIDMORE 12 89 1:30P

FEAL WHITE 12-13-04

ALLEGANY ALLEGANY

CONDELL, SACRED HEART HOSPITAL HUSBAND

ALLEGANY ALLEGANY PROSBURG X 25 FROST VILLAGE

JOHN JONES (MORRE) CARPIS

214-24-032 HOSPITAL RECORDS CONDELL, MD. 100 SEVEN DR. JONES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07759

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 5 Film 413 6/23/69 kk

CERTIFICATE OF DEATH

07751

1. DECEASED-NAME (Type or print) WILLIAM ^{First} R. E. ^{Middle} SMITH ^{Last}		2a. DATE OF DEATH JUNE ^{Month} 15 , 1969 ^{Day}		2b. HOUR 7:05 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-12-97 1897	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during the 30 days immediately preceding death) PRESIDENT-STERLING ELECTRIC	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	
14. FATHER'S NAME ^{First} WILLIAM ^{Middle} H. ^{Last} SMITH		15. MOTHER'S MAIDEN NAME ^{First} KATHERINE ^{Middle} KING ^{Last}			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 214-05-5162		17. INFORMANT Address MEMORIAL HOSPITAL, CUMB. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal cardiac failure, sudden 4124 DUE TO, OR AS A CONSEQUENCE OF (b) acute Bronchial Pneumonia, R.L.L. DUE TO, OR AS A CONSEQUENCE OF (c) A.S. Cardiovascular disease with frequent decompensation 1951 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Pancreatitis and Chronic cholecystitis with cholelithiasis.					
19a. DATE OF OPERATION 6/13/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory laparotomy with cholecystectomy		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 19 51 , to 15 June , 19 69 , that (I) (we) last saw the deceased alive on 15 June , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Alfred Van Ormer, M.D.		22c. DATE SIGNED 16 June 1969		22d. PHYSICIAN'S NAME (Type) DR. W. A. VANORMER	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/17/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service, Cumberland, Md		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland		25a. REC'D BY REGISTRAR 21502	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JUN 17 1969			

03550

03551

WILLIAM T. SMITH JUNE 15, 1963 3:02PM

DATE WHITE 7-15-63 1963 31

COVINGTON U.S.A. X ALLEGANY

COVINGTON MEMORIAL HOSPITAL PRESIDENT-STANLEY ELECTRIC

ALLEGANY COVINGTON X 1100 BEAUFORT ST.

WILLIAM T. SMITH WATERBURY KING

210-65-5122 MEMORIAL HOSPITAL, COV. MO.

COVINGTON X

COVINGTON, MO. W. W. A. VANDER

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07760

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07752

1. DECEASED-NAME (Type or Print) Daniel E. Snider			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month June Day 30 Year 1969			2b. HOUR 10A MIN 00			
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 29, 1901	6. AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS 00 DAYS 00	IF UNDER 24 HRS. HOURS 00 MIN. 00	2c. DATE PRONOUNCED DEAD Month June Day 30 Year 1969			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Machinist		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W.Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11 Jones Steet	
14. FATHER'S NAME First Alonzo Middle Snider Last Snider			15. MOTHER'S MAIDEN NAME First Hattie Middle Smallwood Last Smallwood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes War II		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Mabel Corwell, Ridgeley, W.Va.-Sister					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden -----	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county) Rt. 9, Cumberland, Md.		22b. DATE SIGNED June 30, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 7 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

07140

RECEIVED BY THE OFFICE OF THE SECRETARY OF DEFENSE

07140

1. Name	White	2. Date of Birth	May 20, 1901	3. Grade	Major	4. Branch	Infantry
5. Service Number	USA	6. Component	USA	7. Station	USA	8. Duty Station	USA
9. Component	USA	10. Station	USA	11. Duty Station	USA	12. Component	USA
13. Station	USA	14. Duty Station	USA	15. Component	USA	16. Station	USA
17. Duty Station	USA	18. Component	USA	19. Station	USA	20. Duty Station	USA
21. Component	USA	22. Station	USA	23. Duty Station	USA	24. Component	USA
25. Station	USA	26. Duty Station	USA	27. Component	USA	28. Station	USA
29. Duty Station	USA	30. Component	USA	31. Station	USA	32. Duty Station	USA
33. Component	USA	34. Station	USA	35. Duty Station	USA	36. Component	USA
37. Station	USA	38. Duty Station	USA	39. Component	USA	40. Station	USA
41. Duty Station	USA	42. Component	USA	43. Station	USA	44. Duty Station	USA
45. Component	USA	46. Station	USA	47. Duty Station	USA	48. Component	USA
49. Station	USA	50. Duty Station	USA	51. Component	USA	52. Station	USA
53. Duty Station	USA	54. Component	USA	55. Station	USA	56. Duty Station	USA
57. Component	USA	58. Station	USA	59. Duty Station	USA	60. Component	USA
61. Station	USA	62. Duty Station	USA	63. Component	USA	64. Station	USA
65. Duty Station	USA	66. Component	USA	67. Station	USA	68. Duty Station	USA
69. Component	USA	70. Station	USA	71. Duty Station	USA	72. Component	USA
73. Station	USA	74. Duty Station	USA	75. Component	USA	76. Station	USA
77. Duty Station	USA	78. Component	USA	79. Station	USA	80. Duty Station	USA
81. Component	USA	82. Station	USA	83. Duty Station	USA	84. Component	USA
85. Station	USA	86. Duty Station	USA	87. Component	USA	88. Station	USA
89. Duty Station	USA	90. Component	USA	91. Station	USA	92. Duty Station	USA
93. Component	USA	94. Station	USA	95. Duty Station	USA	96. Component	USA
97. Station	USA	98. Duty Station	USA	99. Component	USA	100. Station	USA

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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07761

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07753

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR
John Snyder		John	Roy	Snyder	June 3 1969		7 p m
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	White	Aug. 18, 1905		63 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md.		U.S.A.				Allegany Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Barton		Rt. 1		Clerk		Gro. Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md		Allegany		Barton		Rt. 1	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First Middle Lost
John Snyder		John	Snyder		Flavia Snyder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		217-01-1525		Helene Snyder-Arlinton, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
CORONARY OCCLUSION, LEFT							SUDDEN
CORONARY THROMBOSIS							--
CORONARY SCLEROSIS							---
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 3, 1969	
				ADDRESS (Street, city, town, or county)		Allegany	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6/6/69		Lanier Hill		Moscow Mills - Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
E. J. Boal - Westernport, Md				JUN 5 1969		Richard Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07762

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07754

1. DECEASED-NAME (Type or print) First Middle Last MAUDIE MAUDIE E. SOLBERG			2a. DATE OF DEATH Month 06 Day 16 Year 69		2b. HOUR 1:00 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 6-1-98		6. AGE (In years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign cause) W. VA.	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALEEGANY Md.	
10. CITY OR TOWN OF DEATH MARYLAND CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT 4
14. FATHER'S NAME First Middle Last JOHN F. BARGER			15. MOTHER'S MAIDEN NAME First Middle Last SARAH COSNER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Address HOSP. REC. 900 SETON DR., CUMB. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTERIOR MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) TIYPARTENSION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from NOV 1968 , to 16 JUNE 1969 , that (I) (we) last saw the deceased alive on 16 JUNE 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Glick				22c. DATE SIGNED 6-16-69	
22d. PHYSICIAN'S NAME (Type) DR. GLICK				22e. ADDRESS 912 SETON DR., CUMB. MD.	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE 6/19/1969		23c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery	
24. FUNERAL DIRECTOR HAFER, 230 BALTI. AVE., CUMBERLAND, MD.		23d. LOCATION (City or Town) (County) (State) Allegheny County Md.		25a. REC'D BY REGISTRAR JUN 18 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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F. SOLBERG

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ACCORD HEART HOSPITAL

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JOHN

HOSP. REC. 000 SETON DR., CUM. ID.

MD

012 SETON DR., CUM. ID.

DR. GLICK

H/PER, 230 BATT. W.F., CONSIDERLY D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07763

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07755

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		Month 6 Day 29 Year 69		4:00 PM		
LILLIAN		MAE		STEELE							
3. SEX	FEMALE		4. RACE	WHITE		5. DATE OF BIRTH	12-19-1904		6. AGE (In years last birthday)	64 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		ALLEGANY		Md.	
BEDFORD, PA.		U. S. A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		CUMBERPLAND		MEMORIAL HOSPITAL	
HOUSEWIFE											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		Homewood Add. PT. #1, BOX 219,	
MD.		ALLEGANY		BA VALE							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
WILLIAM				LAYTON	MARY				BRANTNER	KAUFMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		MEMORIAL HOSPITAL-CUMBERPLAND, MD.			
No.		None									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC Failure-Circulatory Collapse.</u> 154.1 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intestinal Obstruction Recto Sigmoid.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma Rectum.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>26 June, 1969</u> , to <u>29 June, 1969</u> , that (I) (we) last saw the deceased alive on <u>29 June, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Fuller B Whitworth</u> M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>29 June 69.</u>			
22d. PHYSICIAN'S NAME (Type) DR. FULLER B. WHITWORTH						22e. ADDRESS 305 WASHINGTON ST., CUMBERPLAND,					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		7/2/69		Hillcrest Burial Park		Cumberland, Allegany, Md.				MD.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, M.d.						25a. REC'D BY REGISTRAR DATE JUL 3 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

07753

DATE OF BIRTH

04755

STEEL

AGE

11111

12-19-1968

WHITE

FEARLE

ALLEGANY

GEORGE, PA. U. S. A.

CUMBERLAND

MEMORIAL HOSPITAL

ALLEGANY HOSPITAL

60

CATION

11111

MEMORIAL HOSPITAL-CUMBERLAND, PA.

1000

DR. FULLER B. WILKINSON 305 WASHINGTON ST., CUMBERLAND

WILKINSON, FULLER B. (CUMBERLAND, ALLEGANY)

WILKINSON, FULLER B. (CUMBERLAND, ALLEGANY)

486X
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First MELINDA Middle BETH Last STOTT					Month 6 Day 14 Year 69 3:58P M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 6-7-69		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS 7 DAYS 7 HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBEPLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN OLDTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER BOX 9	
14. FATHER'S NAME First LAYTON Middle L. Last STOTT			15. MOTHER'S MAIDEN NAME First MARY Middle A. Last BITTNER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>486X</u> <u>Aspiration</u> <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert D. [Signature]</u>					22c. DATE SIGNED JUNE 18 '69		22d. ADDRESS CHILDRENS MEDICAL GROUP CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 16 '69		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.				
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532					25a. REC'D BY REGISTRAR DATE JUN 20 1969		25b. REGISTRAR'S SIGNATURE <u>Charles [Signature]</u>			

07700

07700

09 3:58P 14 5 2707 1230 11100

6-7-59	WHITE	REMADE
ALLBANY	U.S.A.	WATYLAND
GENERAL HOSPITAL	GENERAL HOSPITAL	GENERAL HOSPITAL
BOX 2	GLUCOSE	WATYLAND
W. 2.	2707	LAYTON 1.
GENERAL HOSPITAL	GENERAL HOSPITAL	GENERAL HOSPITAL

CHILDREN'S MEDICAL GROUP
CHURCHLAND, NO.

5749

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07765		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07757	
1. DECEASED-NAME (Type or print) LAWRENCE EARL LAWRENCE SUMMERS				2a. DATE OF DEATH Month 06 Day 22 Year 69		2b. HOUR P 10:15	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 07-04-12		6. AGE (In years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SUPPLY MAN-WESTERN MD. RAILROAD		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.		13b. COUNTY MINERAL		13c. CITY OR TOWN RIDGELEY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3 SECOND AVENUE		14. FATHER'S NAME First Middle Last JAMES W. SUMMERS		15. MOTHER'S MAIDEN NAME First Middle Last (REED) SARAH BETH K. SUMMERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MD. 21502 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver failure + uraemia 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Biliary + Portal Embosm DUE TO, OR AS A CONSEQUENCE OF (c) Internal biliary fistula due to cholelithiasis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 yrs 10 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 5/9/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Internal biliary fistula		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1959 , to 6/22, 1969 , that (I) (we) lost saw the deceased alive on 6/22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S.G. Weisman				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/23/69	
22d. PHYSICIAN'S NAME (Type) S.G. WEISMAN, M.D.				22e. ADDRESS 59 GREENE ST., CUMB., MD. 21502			
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE 6/25/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George ADDRESS GEORGE FUNERAL HOME-202 GREENE ST., CUMB., MD.				25a. RECD BY REGISTRAR JUN 26 1969 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge	

22550

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-6. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07766

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07758

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR
LINDA		M.		SWAUGER	June 21, 1969				1969	7:30 M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
FEMALE	WHITE	JULY 21, 1952		16 YRS.			Month June 21, Day 1969 Year 19		7:30 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				ALLEGANY		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		SACRED HEART HOSPITAL--DOA				HOUSE WIFE		HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND		ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		158 E. COLLEGE AVENUE		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
GEORGE				BARRY	DOLORES				BOLINGER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
				218-60-1751		MRS. DOLORES BARRY, FROSTBURG, MD. 21532				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Shock										10-15 Min.
DUE TO, OR AS A CONSEQUENCE OF										
(b) Retroperitoneal Hemorrhage										"
DUE TO, OR AS A CONSEQUENCE OF										
(c) Fractured Pelvis										"
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR:MIN 6:45 P.M. June 21 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in auto accident						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. #40		21f. LOCATION Street or R.F.D. No. City or Town County State 0.4 miles west of Frostburg, Allegany, Maryland						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Benedict Skitarelic				M.D.		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 21, 1969		
						ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		JUNE 25, 1969		SUNSET MEMORIAL PARK		CUMBERLAND, MD.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOSEPH R. DURST, FROSTBURG, MD. 21532						JUN 26 1969		[Signature]		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07767

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07759

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			Month	Day	Year	2b. HOUR	
Virginia Caroline Thuss						June			17		1969	4:00 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		May 1, 1910		59 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		USA				Allegany Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		511 Williams St.		Housewife & Beautician Own Home									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Allegany		Cumberland				511 Williams St.					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
William			N.		House	Henrietta Roberts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address							
no						Mr. Ralph J. Thuss, Cumberland, Md. Husband							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL NEOPLASM</u> DUE TO, OR AS A CONSEQUENCE OF <u>(GLIOBLASTOMA MULTIFORME)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mon</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1969</u> , to <u>May 17, 1969</u> , that (I) (we) lost saw the deceased alive on <u>May 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)							
Wayne C. Spiggle		6-18-69				W. C. STIGGLE							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				22f. ADDRESS							
W. C. STIGGLE		CUMBERLAND Md											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Buried		June 20, 1969		Hillcrest Burial Park		Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.						JUN 20 1969		J. Charles Judge					

07750

07750

Female White May 1, 1910

Chamberlain

William F. Boone

Henry L. Boone

Mr. Nathan L. Boone, Chamberlain, Wb.

June 20, 1910

Chamberlain, Wb.

June 20, 1910

Chamberlain, Wb.

June 20, 1910

Chamberlain, Wb.

June 20, 1910

Chamberlain, Wb.

June 20, 1910

Chamberlain, Wb.

June 20, 1910

Chamberlain, Wb.

FOR STATE
HEALTH DEPT.

07768

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07768

1. DECEASED-NAME (Type or Print)			First JAMES			Middle Everett			Last TRAIL			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year			2b. HOUR 12:01a																				
3. SEX Male			4. RACE White			5. DATE OF BIRTH 5/23/35			6. AGE (In years last birthday) 34 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.																				
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany County			2c. DATE PRONOUNCED DEAD Month <input checked="" type="checkbox"/> June 28, 1969			2d. HOUR 12:01a																				
10. CITY OR TOWN OF DEATH Cumberland						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer - Tire & rubber co.						12b. KIND OF BUSINESS OR INDUSTRY																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa.						13b. COUNTY Bedford						13c. CITY OR TOWN RD 1, Flintstone, Md.						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
14. FATHER'S NAME First Ralph						Middle M.						Last Trail						15. MOTHER'S MAIDEN NAME First Lelia C.						Middle O'Neal						Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 200-28-3644						17. INFORMANT Mrs. Leona Trail, RD1, Flintstone, Md.						ADDRESS																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Tamponade</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>819.0</u> (b) <u>Compression Rupture Pulmonary Vein</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(Fractured Sternum)</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Sudden "																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year About 11:30PM 6-27-69						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of Auto involved in accident.																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. #40; 1.3 miles east from top Martins Mt., Allegany, Maryland						21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED																							
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						JUL 2 1969																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE 6/30/69						23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Christian Cem.						23d. LOCATION (City or Town) (County) (State) Southampton Twp., Bed. Co. Penna.																	
24. FUNERAL DIRECTOR Conner Funeral Service, Everett, Pa.						25a. REC'D BY REGISTRAR DATE JUL 2 1969						25b. REGISTRAR'S SIGNATURE <u>Charles Cudde</u>																							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03368

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June 28, 1962

June 28, 1962

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June 28, 1962

FOR STATE
HEALTH DEPT.

07769

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07761

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
George Edward Twigg						Month Day Year			2c. DATE PRONOUNCED DEAD		
Male			White			July 25, 1948			June 17, 1969		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			White			July 25, 1948			20 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
Maryland			USA			NEVER MARRIED			Allegany		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			MEMORIAL HOSPITAL--DOA			Laborer			Construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Allegany			Cumberland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
John W. Twigg			Ora Belle Wertz			no			17. INFORMANT		
						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
						PART I. DEATH WAS CAUSED BY:			MINUTES		
						IMMEDIATE CAUSE (a)			HEMOTHORAX, LEFT		
						DUE TO, OR AS A CONSEQUENCE OF			RUPTURE OF AORTA		
						(b)			MINUTES		
						DUE TO, OR AS A CONSEQUENCE OF					
						(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
				(9:12 P.M. June 17 19 69)				Motorcycle rider head-on crash with car.			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Street				Fairview & Pulaski Sts. Cumberland, Allegany, Maryland			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				BENEDICT SKITARELIC, M.D.				JUNE 17, 1969			
				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town)			
								CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			June 21, 1969			Zion Memorial Park			Cumberland, Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						JUN 20 1969					

James J. Connelley, Cumberland, Md.

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398X
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07770										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07762																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First LAVENIA										Middle M.										Last WADE										6 Month 1 Day 69 Year										12:25 PM									
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH 2-6-86										6. AGE (in years last birthday) 83 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY										Md.									
10. CITY OR TOWN OF DEATH CUMBERLAND										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY ALLEGANY										13c. CITY OR TOWN FROSTBURG										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 255 E. MAIN ST.,									
14. FATHER'S NAME First RANDOLPH										Middle DENNISON										15. MOTHER'S MAIDEN NAME First (RASE) ANNIE										Middle DENNISON										Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no NO (If yes give year and dates of service)										16b. SOCIAL SECURITY NO. 348-12-8584										17. INFORMANT HOSPITAL RECORDS										Address 900 SETON DR. CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3940 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MITRAL STENOSIS & INSUFFICIENCY (c) RHEUMATIC HEART DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from JULY , 19 68 , to 6-1 , 19 69 , that (I) (we) last saw the deceased alive on 6-1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																																																	
22b. SIGNATURE L. M. GLICK MD										DEGREE MD										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 6-1-69																			
22d. PHYSICIAN'S NAME (Type) L. M. GLICK, MD										22e. ADDRESS 912 SETON DR., CUMBERLAND, MD.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE JUNE 4, 1969										23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK										23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.																			
24. FUNERAL DIRECTOR HAFFER-SOWER FUNERAL HOME										ADDRESS FROSTBURG, MD.										25a. REC'D BY REGISTRAR JUN 5 1969										25b. REGISTRAR'S SIGNATURE William Judge																			
VR A15 45M - 1/25																																																	

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12:22 63 1 6 14000 N. LAMAR

FEMALE WHITE 2-0-0 ALL-GUY

CHURCHLAND SACRED HEART HOSPITAL

CHURCHLAND ALLEGANY FROSTBURG 222 E. MAIN ST.

CHURCHLAND DENNIS (CASE) WHITE DENNIS

CHURCHLAND DENNIS (CASE) WHITE DENNIS

CONGESTIVE HEART FAILURE

INITIAL STENOSIS & INSUFFICIENCY

RHEUMATIC HEART DISEASE

L. M. GLICK, MD. 312 DETROIT BL., CHURCHLAND, MD.

HOOPER-SOUL FURNEL HOME, FROSTBURG, MD.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-7. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07771

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07763

1. DECEASED-NAME (Type or Print) ALVIN JOSLIN WALTERS			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year June 19, 1969			2b. HOUR 5:45p M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 27, 1921	6. AGE (In years last birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> June 19, 1969		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DEPOT ROAD			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last ALVIN JOSLIN WALTERS			15. MOTHER'S MAIDEN NAME First Middle Last MARGARET ROBERTS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes give war or dates of service) YES W.W.II		
16b. SOCIAL SECURITY NO. 479-12-2203			17. INFORMANT FROSTBURG, MD. MRS. ALVIN J. WALTERS, DEPOT ROAD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot of Abdomen and Chest DUE TO, OR AS A CONSEQUENCE OF (b) (Self inflicted) DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955X								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
21f. LOCATION State		22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED June 19, 1969
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/22/69		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.		25a. REC'D BY REGISTRAR JUN 30 1969
24. FUNERAL DIRECTOR <i>Marilyn M. Sowers</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS HOME, 60 W. MAIN, FROSTBURG				

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June 19, 1969

June 19, 1969

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Number of copies and cost

(All included)

XX

June 19, 1969

RECEIVED SKETCHES, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07772		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07764			
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
JAMES		ARTHUR	WEISENBORNE	JUNE	Month	15	Year	1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		AUG. 26, 1885		83		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		ELECTRICIAN & FOREMAN		COAL COMPANY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		ECKHART					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
HENRY WEISENBORNE					CATHERINE				KREITZBURG
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (known) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		213-09-6551A		MRS. LOLA WEISENBORNE, ECKHART, MD.		21528			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute brain syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Circulatory disturbance</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>		4379		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		9 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Chronic bilateral obstructive pulmonary disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 28, 1969, to June 15, 1969, that (I) (we) last saw the deceased alive on June 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
A. PAIGE STRONG, M.D.		June 16, 1969							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
		167 E. MAIN ST., FROSTBURG, MD. 21532							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JUNE 18, 1969		ECKHART CEMETERY		ECKHART, MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REGD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOSEPH R. DURST, FROSTBURG, MD. 21532				JUN 20 1969					

0770

STATE OF TEXAS

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Wm. B. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

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MEDICAL CERTIFICATION

07773										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07765									
1. DECEASED-NAME (Type or print) First Middle Last GEORGE F WINFIELD										2a. DATE OF DEATH Month Day Year JUNE 2 1969										2b. TIME OF DEATH PM 11:35									
3. SEX MALE					4. RACE WHITE					5. DATE OF BIRTH 6-28-09					6. AGE (In years lost birthday) 59 YRS.					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) CUMB. MD.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH ALLEGANY Md.														
10. CITY OR TOWN OF DEATH CUMBERLAND					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) B & O R. R.					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.					13b. COUNTY ALLEGANY					13c. CITY OR TOWN CUMBERLAND					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER KNOB RD., BOX 21									
14. FATHER'S NAME First Middle Last WILLIAM J WINFIELD					15. MOTHER'S MAIDEN NAME First Middle Last MARY A HIMMER																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) NO					16b. SOCIAL SECURITY NO. 705-09-3430					17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute anterior myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <u>Arteriosclerosis, heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yrs																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-30</u> , 19 <u>67</u> , to <u>6-2</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-2</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>W. P. Dross MD</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 6-3-69														
22d. PHYSICIAN'S NAME (Type) DR. W. XXXXXX DROSS										22e. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 6/5/69					23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park					23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland														
24. FUNERAL DIRECTOR ADDRESS 21502										25a. REC'D BY REGISTRAR JUN 5 1969					25b. REGISTRAR'S SIGNATURE <u>R. Charles Judge</u>														
Silcox-Merriitt Funeral Service, Cumberland, Md																													

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RECEIVED AT BATH

DATE: 1900 JUL 15

TO: THE SECRETARY OF THE ARMY

FROM: THE SECRETARY OF THE ARMY

SUBJECT: THE SECRETARY OF THE ARMY

RE: THE SECRETARY OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
07774											
07766											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR M			
Betty Ruth Younkin						June 22, 1969					
3. SEX F		4. RACE W		5. DATE OF BIRTH July 16, 1941		6. AGE (In years last birthday) 27 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Minors Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R. D. 1		
14. FATHER'S NAME First Middle Last Clayton Younkin			15. MOTHER'S MAIDEN NAME First Middle Last Ruth Swauger								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT Clayton Younkin		Address Grantsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute brain syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Circulatory disturbance</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Vascular lesion, nature undetermined</u> 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic, severe convulsive disorder</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1969</u> , to <u>June 22, 1969</u> , that (I) (we) lost saw the deceased alive on <u>June 22, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. Paige Strong</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/23/69				
22d. PHYSICIAN'S NAME (Type) A. Paige Strong					22e. ADDRESS Frostburg, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/25/69		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cem.			23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett, Md.				
24. FUNERAL DIRECTOR <u>Kou Newman</u>					ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 25 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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RECEIVED

Handwritten signature

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in agency in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>		
George L. Zimerla						JUNE 17, 1969			12:20		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>
Male	White	Dec. 12 1904	64 YRS.					JUNE 17, 1969			12:20a
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			MEMORIAL HOSPITAL-DOA			Retired Mechanist			Kelly Tire Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Allegany			Cumberland			116 Independent Street.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
William Zimerla			Ursula (Unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes WW II						Mrs. George L. Zimerla			Cumberland Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS, LEFT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY SCLEROSIS</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary emphysema</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			<u>JUNE 17, 1969</u>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6/19, /69			Trinity Luth. Cem.			Cumberland / Allegany / Md.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
Steins Funeral Home, Cumberland, Maryland						JUN 20 1969			<u>Alvin J. Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07768

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR PM		
RUTH		A.		ZOLLNER	JUNE 7 1969		4:35 M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		
FEMALE	WHITE		11-12-1886		82 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD.		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.		ALLEGANY		CUMBERLAND				BOX 2141 STATION A	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
BENJAMIN				BARNHART	LORETTA				SCHLESSER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no				MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic Co of Lung from</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cause of Left Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>yeast</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1967</i> to <i>June 7, 1969</i> , that (I) (we) lost saw the deceased alive on <i>June 7, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B. Schindler</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6/8/69</i>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
DR. BLANE SCHINDLER		43 GREENE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 10, 1969		Mt. Oliver Cemetery		Near Hancock, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.				JUN 11 1969		<i>Charles Judge</i>			

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